UNITED HOSPITAL
Care Par Excellence

DEPARTMENT OF LABORATORY MEDICINE

Patient Name	: Mr. PAREDDY BHARATH REDDY	Order No	: 1000102713
UHID	: UHJA24007785	Registered On	: 09/11/2024 08:35:54 AM
Age/Sex	: 39/Years Male	Collected On	: 09/11/2024 08:53:57 AM
Ward / Bed No	:	Reported On	: 09/11/2024 03:18:22 PM
Reference	: Dr. Ashmitha Padma	Bill No	: OPBJA240010512
Station	: At Hospital	Mobile No	: 9677691767
Payer Name	: Mediwheel	Report Status	: Final Report

Test Name	Result	Unit	Bio. Ref. Interval
	BIOCHEMISTRY		
FASTING GLUCOSE (Method: Hexokinase)	83	mg/dL	ADA Guidelines < 100 mg/dl - Normal 100 to 125 mg/dl - Prediabetes ≥ 126 mg/dl - Diabetes
POST PRANDIAL GLUCOSE (Method: Hexokinase)	110	mg/dL	70-140
GLYCOSYLATED HAEMOGLOBIN (HBA1C)			Sample: Whole blood (EDTA)
HBAIC (Method: HPLC)	5.0	%	ADA Guidelines < 5.7% - Normal 5.7 to 6.4% - Prediabetes ≥ 6.5% - Diabetes
Estimated Average Glucose (eAG) (Method: Calculated)	97	mg/dL	
THYROID PROFILE (TOTAL T3, TOTAL T4 & TSH)			Sample: Serum
TOTAL T3 (Method:CLIA)	1.08	ng/mL	0.87-1.78
TOTAL T4 (Method:CLIA)	11.72	≈g/dL	5.1-14.1
THYROID STIMULATING HORMONE (TSH) (Method:CLIA: Ultra-sensitive)	1.20	ı IU/mL	0.34-5.60
LIPID PROFILE			Sample: Serum
TOTAL CHOLESTEROL (Method:CHOD-POD)	184	mg/dL	ATP III Guidelines < 200 - Desirable 200-239 - Borderline high ≥ 240 - High
TRIGLYCERIDES (Method:Enzymatic GPO-POD)	81	mg/dL	< 150 - Normal 150-199 - Borderline High 200-499 - High ≥ 500 - Very High
HDL CHOLESTEROL (Method:ENZYMATIC METHOD)	47.8	mg/dL	< 40 - Low ≥ 60 - High

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Test Name	Result	Unit	Bio. Ref. Interval
LDL CHOLESTEROL (Method: Calculated)	120.00	mg/dL	<100 - Optimal 100-129 - Near or above optimal 130-159 - Borderline high 160-189 - High ≥190 - Very high
VLDL CHOLESTEROL (Method: Calculated)	16.20	mg/dL	< 30
TOTAL CHOLESTEROL : HDL RATIO (Method: Calculated)	3.85		Low Risk: 3.3 - 4.4 Average Risk: 4.5 - 7.1 Moderate Risk: 7.2 - 11.0
LDL/HDL CHOLESTEROL RATIO (Method: Calculated)	2.51		< 2.5 Optimal
NON HDL CHOLESTEROL (Method: Calculated)	136.20	mg/dL	< 130
URIC ACID (Method:Uricase - POD(Enzymatic))	3.4	mg/dL	3.5-7.2
CREATININE (Method:Modified Jaffe, Kinetic)	0.71	mg/dL	0.9-1.3
LIVER FUNCTION TEST			Sample: Serum
TOTAL BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.98	mg/dL	0.3-1.2
DIRECT BILIRUBIN (Method:Dichlorophenyl Diazotization)	0.22	mg/dL	0.0-0.2
INDIRECT BILIRUBIN (Method: Calculated)	0.76	mg/dL	0.2-1.0
TOTAL PROTEIN (Method:BIURET)	7.3	g/dL	6.6-8.3
ALBUMIN (Method:BCG)	4.64	g/dL	3.5-5.2
GLOBULIN (Method: Calculated)	2.66	g/dL	2.3-3.5
AG RATIO (Method: Calculated)	1.74		2:1

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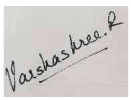
Test Name	Result	Unit	Bio. Ref. Interval
SERUM SGOT (Method:IFCC without P5P)	38	U/L	< 50
SERUM SGPT (Method:IFCC without P5P)	27	U/L	< 50
ALKALINE PHOSPHATASE, SERUM (Method:PNPP AMP Buffer)	68	U/L	50-116
GGT (Method:IFCC)	14	U/L	< 55



Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

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HAEMATOLOGY

COMPLETE BLOOD COUNT(CBC) — Sample: Whole blood (EDTA)

Test Name	Result	Unit	Bio. Ref. Interval
HAEMOGLOBIN (Method:Photometric Measurement: Oxyhemoglobin method)	14.72	g/dL	13.5-17.5
PACKED CELL VOLUME/HEMATOCRIT (PCV/HCT) (Method: Calculated)	46.0	%	42-52
TOTAL WBC COUNT (TLC) (Method:Coulter Principle)	4960	Cells/Cum	4000-11000
DIFFERENTIAL COUNT			
NEUTROPHILS (Method:Optical/Impedance)	59.53	%	40-75
LYMPHOCYTES (Method:Optical/Impedance)	30.87	%	20-45
EOSINOPHILS (Method:Optical/Impedance)	1.36	%	0-6
MONOCYTES (Method:Optical/Impedance)	7.79	%	2-10
BASOPHILS (Method:Optical/Impedance)	0.45	%	0-2
RED BLOOD CORPUSCLES(RBC) (Method:Coulter Principle)	5.76	million/cum	4.5-5.9
MCV (Method:Derived from RBC Histogram)	79.9	fL	78-100
MCH (Method: Calculated)	25.6	pg	27-31
MCHC (Method: Calculated)	32.0	g/dL	31-37
RDW - CV (Method: Calculated)	15.2	%	11.5-14.5
PLATELET COUNT (Method:Electrical Impedance)	1.73	Lakhs/Cum	1.5-4.5

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Test Name	Result	Unit	Bio. Ref. Interval
MEAN PLATELET VOLUME(MPV) (Method:Derived from PLT Histogram)	7.60	fl	9-13
PLATELET DISTRIBUTION WIDTH (PDW) (Method: Calculated)	17.5	fl	9-19
ABSOLUTE NEUTROPHIL COUNT (ANC) (Method: Calculated)	2950	Cells/Cum	1500-7500
ABSOLUTE EOSINOPHIL COUNT (AEC) (Method: Calculated)	70	Cells/Cum	40-440
ABSOLUTE LYMPHOCYTE COUNT (ALC) (Method: Calculated)	1530	Cells/Cum	1000-4000
ABSOLUTE MONOCYTE COUNT (AMC) (Method: Calculated)	390	Cells/Cum	200-1000
ABSOLUTE BASOPHIL COUNT (ABC) (Method: Calculated)	20	Cells/Cum	20-100
ERYTHROCYTE SEDIMENTATION RATE(ESR) (Method:Modified Westergren Method)	05	mm/hour	1-15

BLOOD GROUPING & RH TYPING — Sample: Whole blood (EDTA)

ABO Group (Method:Agglutination Method)	A	
Rh Factor (Method:Agglutination Method)	Positive	

Interpretation Notes

Note: Both forward and reverse grouping performed

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CLINICAL PATHOLOGY

Sample: Urine

Test Name	Result	Unit	Bio. Ref. Interval
URINE EXAMINATION, ROUTINE			
PHYSICAL EXAMINATION			
VOLUME	25	mL	
COLOUR	Pale Yellow		
APPEARANCE	Clear		
PH	6.0		5.0-8.0
SPECIFIC GRAVITY	1.005		1.005-1.030
CHEMICAL EXAMINATION			
PROTEIN (Method:Protein Error of pH Indicator)	Absent		Absent
GLUCOSE (Method:GOD-POD)	Absent		Absent
KETONE BODIES (Method:Nitroprusside method/ Rothera's test)	Absent		Absent
BILIRUBIN (Method:DIAZO/FOUCHET'S TEST)	Negative		Negative
BILE SALT (Method:Hay's sulfur test)	Absent		Absent
NITRITE (Method:Griess method)	Negative		Negative
UROBILINOGEN (Method:Azo coupling method)	Normal		
LEUKOCYTE ESTERASE (Method:Leukocyte Esterase activity)	Negative		Negative
BLOOD (Method:Peroxidase Reaction)	Negative		Negative
MICROSCOPIC EXAMINATION			

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Test Name	Result	Unit	Bio. Ref. Interval
EPITHELIAL CELLS	0-2	/HPF	0-5
PUS CELLS	2-4	/HPF	0-5
RBCs	Nil	/HPF	0-2
CASTS	Nil	/LPF	
CRYSTALS	Nil		
OTHERS	Nil		
URINE SUGAR, FASTING (Method:GOD-POD)	Absent		
URINE SUGAR (POST PRANDIAL)	Absent		

Verified By
Rashmita

---End of Report---

Dr. Varsha Shree R
M.D(Pathology)
CONSULTANT PATHOLOGIST
KMC No : 103567

ID: 24007785
Name: MR PAREDDY

9-Nov-2024 AM9:24:06

Sex: M Birth date: 39 years

cm kg / mmHg

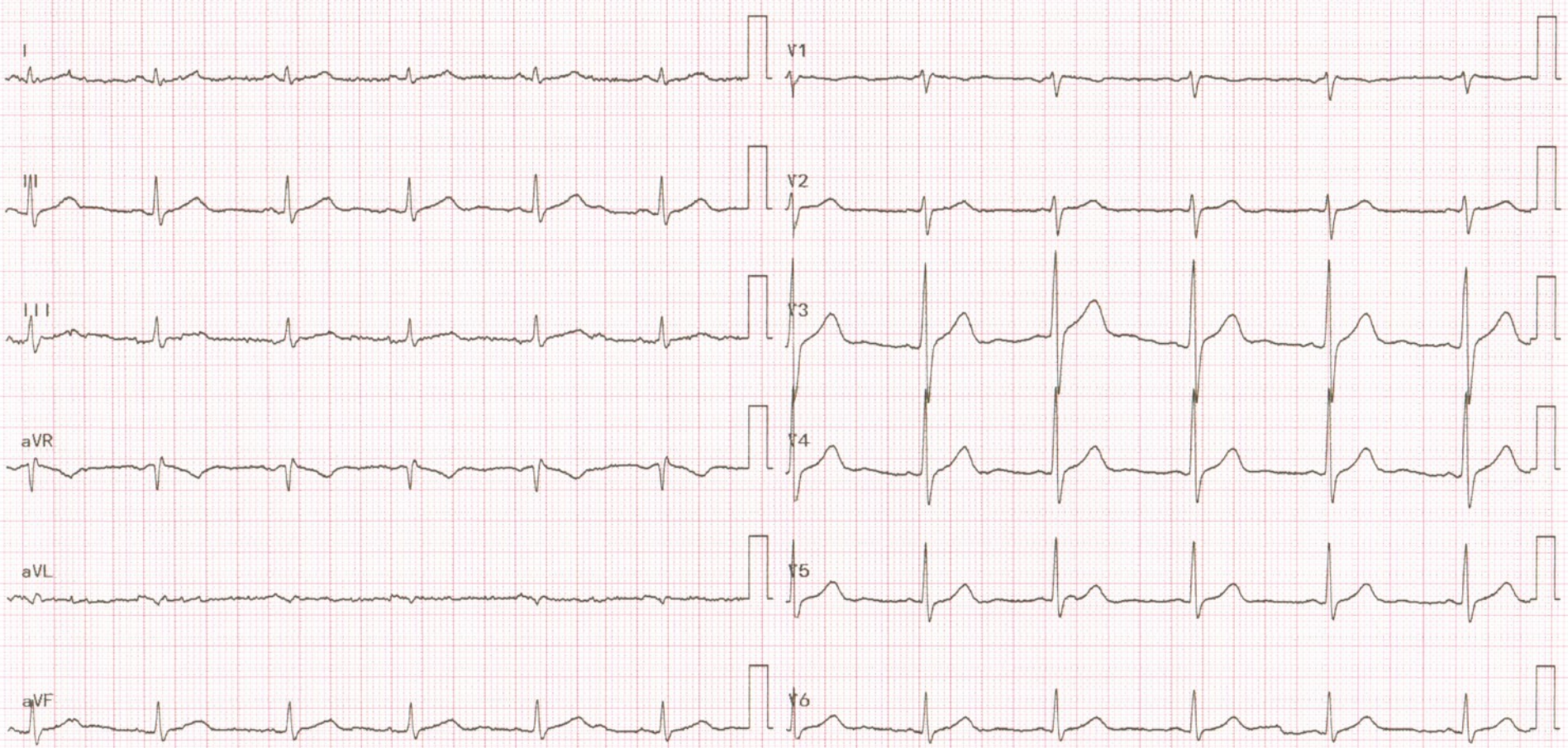
Medication:
Symptoms:
History:

Vent. rate	71	bpm
PR int	132	ms
QRS dur	98	ms
QT/QTc(E) int	380/ 402	ms
P/QRS/T axis	20/ 71/ 61	°
RV5/SV1 amp	1.03/ 0.36	mV
RV5+SV1 amp	1.39	mV

1100 Sinus rhythm
9110 ** normal ECG **

Unconfirmed Report
Reviewed by:

10 mm/mV 25 mm/s Filter: H50 D 35 Hz 10 mm/mV



2350K 03-08 07-01 Dept.: Exam: UNITED HOSPITAL

DEPARTMENT OF RADIODIAGNOSIS

Name	Paredddy Bharath Reddy	**Date**	09/11/24
Age	39 years	**Hospital ID**	UHJA24007785
Sex	Male	**Ref.**	Health check

ULTRASOUND ABDOMEN AND PELVIS

FINDINGS:

Liver is normal in size and echopattern. No intra or extra hepatic biliary duct dilatation. No focal lesions. **Portal vein** is normal in caliber. **CBD** is not dilated.

Gall bladder is normal without evidence of calculi, wall thickening or pericholecystic fluid.

Pancreas - Visualized part of the pancreatic head and body appears normal in size, contour and echogenicity. Rest of the pancreas is obscured by bowel gas.

Spleen is normal in size, shape, contour and echopattern. No focal lesion.

Right Kidney is normal in size (10.1 x 3.9 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.
Left Kidney is normal in size (11.5 x 4.0 cms), position, shape and echopattern. Corticomedullary differentiation is maintained. No calculus or hydronephrosis.

Retroperitoneum - Visualized aorta appeared normal. No obvious enlarged para-aortic nodes.

Urinary Bladder is distended, normal in contour and wall thickness. No evidence of calculi.

Prostate is normal in echopattern and size, measures ~ 17.2 cc.

No ascites or pleural effusion. Appendix could not be localized. No RIF probe tenderness.

IMPRESSION:

- **No definite sonological abnormality detected.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
Care Par Excellence
Jayanagar, Bangalore

Patient name :	**Mr. PARAREDDY BHARATH**	**Date :**	**09/11/24**
Age :	**39 years GENDER: MALE**	**Patient ID :**	**24007785**
Ref by :	**CMO**	**OP/IP :**	**HEALTH CHECK**

2D- ECHOCARDIOGRAPHY

M – MODE AND DOPPLER MEASUREMENTS

(c.m)	(c.m)	(cm/sec)		
AO : 3.2 (2.5-3.7)	LVIDD : 4.2 (3.5-5.5)	MV EV : 0.6	AV : 0.5	MR : NORMAL
LA : 2.8 (1.9-4.0)	LVIDS : 2.6 (2.4-4.2)	AV : 0.7		AR : NORMAL
RA : 2.0 (<4.4)	IVSD : 0.9 (0.6-1.1)	PV : 0.8		PR : NORMAL
RV : 1.9 (<3.5)	IVSS : 1.0 (0.9-1.2)	TV EV : ------	AV : ------	TR : NORMAL
TAPSE: 1.7 (>1.6)	LVPWD 1.1 (0.6-1.1)	Diastolic Function : NO LVDD		
	LVPWS : 1.2 (0.9-1.2)			
	EF : 60%			

DESCRIPTIVE FINDINGS

Left Ventricle	: NORMAL
Right Ventricle	: NORMAL
Left Atrium	: NORMAL
Right Atrium	: NORMAL
Wall motion analysis: NO RWMA	
Mitral Valve	: NORMAL
Aortic Valve	:NORMAL
Tricuspid Valve	: NORMAL
Pulmonary Valve	: NORMAL
IAS	: INTACT
IVS	: INTACT
Pericardium	: NORMAL
Other Findings	: IVC NORMAL

IMPRESSION :

BRADYCARDIA OBSERVED DURING THE STUDY (HR -58 bpm)
NORMAL CHAMBER DIMENSIONS
NORMAL LV SYSTOLIC FUNCTION EF : 60%
NORMAL LV DIASTOLIC FUNCTION
NO PULMONARY ARTERY HYPERTENSION
NO REGIONAL WALL MOTION ABNORMALITIES
NO CLOTS/ PERICARDIAL EFFUSION /VEGETATION

DR.RAHUL PATIL
CONSULTANT CARDIOLOGIST

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangaloro

DEPARTMENT OF RADIODIAGNOSIS

Name	Paredddy Bharath Reddy	**Date**	09/11/24
Age	39 years	**Hospital ID**	UHJA24007785
Sex	Male	**Ref.**	Health check

RADIOGRAPH OF THE CHEST (PA – VIEW)

FINDINGS:

Bilateral lung fields are normal.

Bilateral costo-phrenic angles are normal.

Cardia and mediastinal contours are normal.

The bony thorax is grossly normal.

IMPRESSION:

- **No radiographic abnormality.**

Dr. Elluru Santosh Kumar
Consultant Radiologist

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Out Patient Record

Patient Name	: Mr.PAREDDY BHARATH REDDY	UHID	: UHJA24007785
Age / Sex	: 39 Years / Male	OP NO/Reg Dt	: 09-11-2024 08:35 AM
Spouse / Father Name	: KALYANI KANTHALA	Department	:
Address	: ., , Bengaluru Urban, Karnataka, INDIA.	Refered By	:
		Consultant	: Dr.Ashmitha Padma MBBS, MD (GENERAL MEDICINE), PGDCC,FEM
		KMC No.	: 02M1087

Complaints / Findings / Observations :

Ht - 176 cm
Wt - 68.2 kg
BP - 118/80
PR - 96/min
SpO2 - 99%

Investigations:

Treatment / Care of Plan / Provisional Diagnosis :

Follow Up Advice :

Signature of the Doctor

No.1

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		KMC No.	: 02M1087

omplaints / Findings / Observations :

Health Check up

No Symptoms

NO Comorbs

Ht - 176 cm
Wt - 68.2 kg
BP - 118/80
PR - 76/min
SPO2 - 99-1

vestigations:

Bloods
N

2DECHO:
Bradycardia - HR-58

O/E: CVS: S1S2G1
RS: BLNVBS(+)

eatment / Care of Plan / Provisional Diagnosis :

Advice

LUG - (N)
ECG - non significant
Changes noted

(1) TAB Zinlovit o-1-0 x 15 days

(2) Life style modifications as advised

(3) Review SOS

(4)

llow Up Advice :

Dr. Aiyyaz Faizal

Signature of the Doctor

No.1

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vestigations:

Blood,
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HR-58

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ECG - Non significant changes noted

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low Up Advice :

(4)

Dr. Aayaz Saeed

Signature of the Doctor

NABH No.1

UNITED HOSPITAL
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Jayanagar, Bangalore

Mr. Poreddy Bharath Reddy
39Yrs/Male

Opthal
9/11/24
Dr. Shwetha.

H/o Eales disease.

S/p Laser, RE Vitrectomy ... long back (BE)

VA (glass): 6/12P, 6/12p. } ...

nil symptoms

Ads: OU normal

Fundus: OU CD ratio 0.3:1, FR (+).
Laser scars (+).

9/11/24

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